

400512

STANDARD CERTIFICATE OF DEATH
FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
NATIONAL OFFICE OF VITAL STATISTICS

ARIZONA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

State File No. 5489

Registrar's No. _____

1. Place of Death: (a) County Maricopa (b) City or Town Wickenburg (c) Location Community Hospital
(If outside city limits also write RURAL) (St. & No. (or) Name of Institution)

(d) Length of Stay: In Hospital or Institution 10 days; In Community 10 days; In Arizona 3 years
(Specify whether years, months or days)

2. Usual Residence of Deceased: (a) State Arizona; (b) County Maricopa (c) City or Town Maricopa
(If outside city limits also write RURAL)

(d) Street No. _____ (e) Citizen of foreign country (Yes or No) _____

3. (a) FULL NAME John Henry Bliss (b) If veteran name war _____ (c) Social Security No. _____

4. Sex male 5. Race White ☒ Indian ☐ Negro ☐ 6. (a) Single, married, widowed or divorced married

6. (b) Name of husband or wife Agnes Ruth Bliss 6. (c) Age of husband or wife, if alive 40 yrs.

7. Birthdate of deceased Jan 24 1881
(Month) (Day) (Year)

8. AGE: Years 67 Months 8 Days 17 hrs. _____ min _____
If less than one day

9. Birthplace Fall River Wisconsin
(City, town or county) (State or Country)

10. Usual Occupation Retired

11. Industry or Business _____

12. Name John H. Bliss

13. Birthplace Fall River Wisconsin
(City, town or county) (State or Country)

14. Maiden Name Clara Smith

15. Birthplace Fall River Wisconsin
(City, town or county) (State or Country)

16. (a) Informant's own signature Bitte Mahabub
(b) Address 1928 16th Ave. S. Minneapolis, Minn.

17. (a) Burial, Cremation or Removal Removal
(b) Place Minneapolis, Minn. (c) Date 10-7-1948

18. (a) Embalmer's Signature H. L. Coffinger

(b) Funeral Director H. L. Coffinger

(c) Address Wickenburg, Arizona

19. (a) 10/7/48 (Date received Local Registrar)

(b) Mani Coffinger (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month, day and year) Oct. 6, 1948
TIME (Hour and minute) 2:20 P. M.

21. I hereby certify that I attended the deceased from Sept. 25, 1948 to October 6, 1948

that I last saw him alive on October 6, 1948

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Arteriosclerotic and Hypertensive Cardiovascular Disease

Due to _____

Other conditions None
(Include pregnancy within three months of death)

Major findings: None

Of operations None

Of autopsy None

DURATION

22. If death was due to external causes, fill in the following:

(a) Accident, suicide or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or Town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature William M. Henry M. D.

Address Wickenburg Date signed 7 Oct 48